

The COVID-19 Law and Policy Challenge

**Reforming the Global Health Law
Regime in light of COVID-19**



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Reforming the Global Health Law Regime in light of COVID-19

Introduction

The management of the novel coronavirus has raised key questions regarding the adequacy of the existing international health law regime in effectively countering an outbreak of this magnitude. The structure and operational failures of the World Health Organization (WHO) have been brought to the fore by Member States - with some countries withdrawing membership or cutting funding, while others denigrating the body for becoming politically motivated. There is also criticism that the current International Health Regulations (2005) framework leaves too much room for national discretion, with States delaying reporting outbreaks of novel non-communicable diseases, such as COVID-19, resulting in a haphazard response at the international level. These critiques necessitate a deeper understanding of the global health governance framework and the ways in which it falls short of effectively countering a global pandemic. This paper highlights the fallacies of the existing framework of international health governance, and further contextualises Pakistan's experience of countering COVID-19. It concludes with identifying recommendations that can be incorporated to improve responses to pandemics and other health emergencies internationally.

The Law: Powers of the WHO and the International Health Regulations (2005)

Constitution of the World Health Organization

The World Health Organization (WHO) is a United Nations specialized agency, armed with a wide mandate that includes coordinating international action to boost public health and enable “the attainment by all peoples of the highest possible level of health.” However, it differs from other international organizations (IOs) and specialized agencies because its Constitution allows it unique legislative and quasi-legislative powers, as well as the ability to pass resolutions through the World Health Assembly (WHA).

Article 19 of the Constitution provides the authority for the WHO (via the WHA) to adopt conventions or agreements with respect to any matter 'within the competence of the Organization.' This provides the WHO with the authority to exercise its wide-ranging constitutional objectives and

functions within the health sphere.¹ Currently, the only conventions and treaties that have been successfully negotiated has been the Framework Convention on Tobacco Control (FCTC) in 2003 and the International Health Regulations (IHR), which were widely ratified and implemented by UN Member States.

Article 21 of the Constitution allows the WHA to adopt regulations concerning “(a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease; (b) nomenclatures with respect to diseases, causes of death and public health practices; (c) standards with respect to diagnostic procedures for international use; (d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce; (e) advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.”

Article 22 states that these measures will come into force for all members after due notice, unless some States express reservations or rejection within a designated period. According to Alison Lakin, these “regulations” are closer to treaties than broader recommendations in the sense that they create legal rights and duties which are binding on States, yet States are also granted enough latitude to give effect to the regulation domestically, as appropriate.

Article 23 empowers the WHA “to make recommendations to Members with respect to any matter within the competence of the Organization.” There is some confusion as to the precise legal nature of recommendations, i.e., whether they are persuasive with binding legal force. Some experts assert that recommendations carry “a measure of legality.”² However, it is useful to consider the ways through which the WHO issues these recommendations and the degree of their binding legality. These include: WHA Resolutions (no legal obligation, but a contractual obligation exists), codes of conduct (no legal obligation for implementation), technical standards (more pragmatic and expert oriented than political/legal) and other recommendations (WHO publications and existing corpus of technical rules – not binding).³

¹ Lakin, A. (1997). *The Legal Powers of the World Health Organization*. *Medical Law International*, 3(1), 23–49.

² Ibid.

³ Lakin, A. (1997). *The Legal Powers of the World Health Organization*. *Medical Law International*, 3(1), 23–49.

According to Lakin, recommendations have broadly been the preferred choice of WHO in using its powers to attain its objectives⁴ and there are virtually no limits on the issuance and use of recommendations.

Articles 61-62 of the Constitution create an obligation for each member to “report annually on the action taken and progress achieved” by the people as well as in terms of implementing recommendations, conventions, agreements and regulations. However, States conform to this obligation erratically and there is little willingness to compel States by the WHO.

*International Health Regulations (2005)*⁵

The International Health Regulations (2005)⁶ are a legally binding instrument of international law that assist countries in working together to save lives and livelihoods endangered by the international spread of diseases.

They entered into force in June 2007 creating a global framework to prevent, detect, assess and provide a coordinated response to events that may constitute a Public Emergency of International Concern (or PHEIC).⁷ Article 1 of the IHR defines a PHEIC as “an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response.”⁸ Thus, a PHEIC denotes not only the increased susceptibility of disease spread across borders, but it requires a timely, multifocal and coordinated response from States and the WHO. International public health security relies on the appropriate and timely management of public health risks, which in turn depend on effective national capacities and international and inter-sectoral collaboration. Thereby, the IHR comprise a legal instrument specifically designed to support the attainment of this goal.

The IHR focuses on critical areas of work that broadly revolve around four themes: fostering global partnership, strengthening national capacity, preventing and responding to PHEICs and legal issues

⁴ Ibid.

⁵ International Health Regulations (2005) – World Health Organization Publications
<https://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf?sequence=1>

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

and monitoring.⁹ The articles contained within the IHR not only create obligations on States towards the provision of health services, but also strengthens the functions of the WHO, particularly its global alert and response systems, and the management of risks.

State obligations under IHR¹⁰

According to Article 3, States must adhere to the full spectrum of human rights and the guidance provided by the Charter of the United Nations and the Constitution of the World Health Organization. This ensures that fundamental rights of the affected, as well as other segments of the public, such as travelers, vulnerable demographics or those at risk, are protected in light of the WHO and the broader UN Charter. In addition, States have the right to legislate and implement legislation in pursuance of health policies while “upholding the purpose of the IHR” as per the principles of international law. This means that while the IHR provides recommendations and regulations to be implemented by States, the States can choose to adopt these in line with their own domestic legal and governance systems, socio-political contexts and policies.¹¹ In implementation of health measures broadly, States are obligated to uphold the rights of travelers and ensure international traffic is not disrupted; in case of disruptions are unavoidable, research-backed evidence of human risk to human health and other data must be shared with the WHO authorities.¹²

According to Article 5, States are mandated to develop core capacity requirements to “detect, assess, notify and report events in accordance with the regulations” within the ambit of wider disease surveillance. The WHO can further assist in State Parties to develop, strengthen and maintain these required capacities if requested. Article 6 further obligates State Parties to report by the most efficient means of communication, all events which may constitute a public health emergency of international concern (PHEIC) within its territory within 24 hours of its assessment. Following this, the State is required to maintain close communication with the WHO regarding the spread of the

⁹ Areas of Work – World Health Organization

https://apps.who.int/iris/bitstream/handle/10665/69770/WHO_CDS_EPR_IHR_2007.1_eng.pdf?sequence=1

¹⁰ World Health Organization International Health Regulations (2005).

<http://www.who.int/ihr/publications/9789241596664/en/>

¹¹ International Health Regulations - Toolkit for Legislative Implementation, World Health Organization (WHO)

https://www.who.int/ihr/Toolkit_Legislative_Implementation.pdf?ua=1

¹² Article 43, International Health Regulations (IHR) - (2005). World Health Organization

<http://www.who.int/ihr/publications/9789241596664/en/>

disease, measures employed, difficulties encountered, and other information. The aim is to create a robust system of reporting in PHEICs and other potential outbreaks in order to “respond promptly and effectively to public health risks.”¹³ In case of unprecedented outbreaks of a novel disease, States are obligated to notify the WHO and share all relevant information¹⁴ in a timely manner to garner effective response.

Article 54 creates obligations on State Parties for reporting and review of implementation of IHR in the WHA.¹⁵ The WHO is also empowered to periodically conduct studies to evaluate the functioning of the Regulations, submitting these to the WHA for review and deliberation. Article 56 governs dispute settlement mechanisms. According to this, in case of a dispute regarding the IHR, State Parties are mandated to resolve the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation or conciliation. If the dispute is not settled, the States Parties may refer the dispute to the Director-General, who shall make every effort to settle it, or refer to arbitration. In case the dispute is between the WHO and State Parties, the matter shall be submitted to the WHA.

Key Concerns under the Current Framework

Poor Monitoring and Accountability of Member States

Despite extended compliance deadlines, no Member State is in complete compliance with the IHR’s core competencies - including detection, assessment, notification, reporting and responding to public health risks¹⁶. Europe achieved the highest level of compliance at 72% across all competencies, and Africa ranked the lowest at 44% according to the WHO’s State Parties Self-Assessment Annual Reporting Tool (“SPAR”).¹⁷ Notably, however, the SPAR (discussed below) has

¹³ Articles 5, 13, 19-22, International Health Regulations (IHR) - (2005). World Health Organization <http://www.who.int/ihr/publications/9789241596664/en/>

¹⁴ Article 7, International Health Regulations (IHR) - (2005). World Health Organization <http://www.who.int/ihr/publications/9789241596664/en/>

¹⁵ Article 54, International Health Regulations (IHR) - (2005). World Health Organization <http://www.who.int/ihr/publications/9789241596664/en/>

¹⁶ Articles 5, 13, Annex 1 - International Health Regulations (2005). World Health Organization <http://www.who.int/ihr/publications/9789241596664/en/>

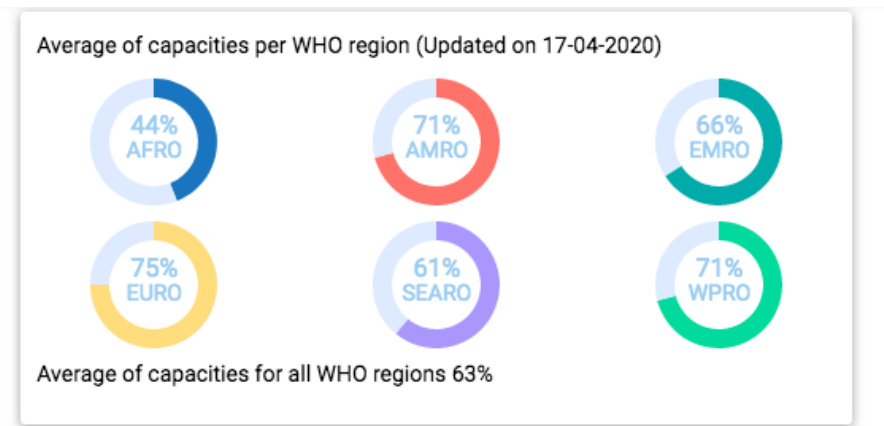
¹⁷ State Party Annual Report (SPAR) 2020 –World Health Organization <https://extranet.who.int/e-spar/#submission-details>

Key:

AFRO = WHO Regional Office for Africa;

AMRO = WHO Regional Office for the Americas;

been criticized for its lack of independent validation. National evaluation of compliance is also seen as inconsistent, presenting challenges in implementing the IHR regimes.¹⁸



According to the Report of the High Level Panel¹⁹, only a third of the 196 State Parties to the International Health Regulations have reported compliance to the IHR core capacity requirements. However, despite having 128 non-compliant countries, the WHO has not been able to enforce implementation of the IHR framework, primarily due to the absence of an effective review mechanism.

There are predominantly three reasons for the weak monitoring and evaluation mechanism – the voluntary nature of self-assessments by Member States, the lack of financial assistance to support implementation in poorer countries, and the absence of sanctions for non-compliance.²⁰ In terms of financing particularly, it is important to note that imposing similar sanctions upon developing and developed nations for non-compliance will set unreasonable standards and expectations. Not only have previous efforts²¹ to reinforce compliance via sanctions such as trade tariffs and embargoes

EMRO = WHO Regional Office for the Eastern Mediterranean;

EURO = WHO Regional Office for Europe;

SEARO = WHO South-East Asia Regional Office;

WPRO = WHO Regional Office for the Western Pacific.

¹⁸ Tonti, Lauren. “The International Health Regulations: The Past and the Present, But What Future?” Harvard International Law Journal, April 21, 2020. <https://harvardilj.org/2020/04/the-international-health-regulations-the-past-and-the-present-but-what-future/>.

¹⁹ supra note 7, page 47

²⁰ Supra note 7, page 47

²¹ past efforts have included discussions circulating the plausibility of imposing sanctions. (A joint study by the WHO and WTO Secretariat)

proved unsuccessful,²² but it is also irrational to expect countries with limited resources to build core capacities such as surveillance and laboratory services without financing or technical support. In case any State is in violation of any recommendation of the WHO that has been issued during a PHEIC, that can be challenged both under the IHR and the World Trade Organization (WTO)²³ dispute settlement procedures outlined in Article 53 of the IHR. The WTO has created exceptions for restrictions on trade under Articles XX-XXI of the General Agreement of Trade in Services (GATS) in cases of threats of health and safety, applicable to PHEICs. As of yet, no case has been brought before the WTO for adjudication for reasons pertaining to the measures taken by a member State in a PHEIC.²⁴

The IHR Core Capacity Monitoring Framework 2010 accompanied by the IHR Monitoring Tool identifies 8 specific core capacities (Laboratories, Human Resources, Surveillance, Preparedness, Response, Risk Communication, Coordination and National IHR Focal Point (NFP), National legislation, policy and financing) as well as 5 other capacities concerning points of entry and specific hazards. For evaluation of implementation of these 13 capacities, Member States are expected to assess their own compliance to them and then report it to the WHO. Under the IHR Monitoring tool, the State Parties were expected to issue formal reports to the WHO in 2012 (with additional reports in 2014 and 2016 for governments that requested extensions) in light of their compliance to the IHR regulations. However, in 2014 only 64 State Parties reported meeting core capacities while 48 countries failed to respond to the WHO²⁵. The Reporting did indicate a significant increase after Self-Assessment Annual Reporting Tool (SPAR) was introduced but still did not reflect complete compliance.²⁶ Nevertheless, even if the countries had managed to report in a timely manner, the crux of the problem lies in the voluntary nature of the self-assessment mechanism, which has prevented States from issuing an objective evaluation of their national preparedness plan. Self-Assessments are

“WTO Agreements and Public Health.” World Health Organization - World Trade Organization, 2002. https://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf.

²² Supra note 7, page 48

²³ Zhou, Jingyuan. "Guest Post: Facilitating WTO-compliant Responses to International Public Health Emergencies." International Economic Law and Policy Blog. Accessed July 30, 2020. https://ielp.worldtradelaw.net/2020/03/guest-post-facilitating-wto-compliant-responses-to-international-public-health-emergencies-introduct.html#_edn20.

²⁴ Ibid.

²⁵ WHO. Implementation of the International Health Regulations (2005): report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation: report by the Director General. March 27, 2015: para. 17. http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf. Accessed May 27th, 2020.

²⁶ Ibid.

thus deemed to be “inherently self-interested and unreliable, absent rigorous independent validation.”²⁷

SPAR (Self-Assessment Annual Reporting Tool) and its Challenges

The IHR Monitoring and Evaluation Framework consists of four components; the State Party Self-Assessment Annual Report, (annual reporting is mandatory as per Article 54 of the IHR) and three voluntary assessments namely Joint External Evaluation (JEE), after action reviews and simulation exercises. For the COVID-19 pandemic, a monitoring and evaluation (M&E) framework has been prepared to facilitate monitoring at the global and national level. The SPAR tool consists of 24 indicators for the 13 IHR capacities needed to detect, assess, notify, report and respond to PHEIC.²⁸ While annual reporting is mandatory, the use of the SPAR tool is completely voluntary.²⁹ However, the biggest problem in the implementation of this approach lies in the coordination and collaboration of the national focal points (NFPs) with other sectors. In fact, the challenges to the multi-sectoral action may be more acute in low-income and middle-income countries, where the institutions are relatively more fragile and the governance structure is more fragmented; these factors undermine multi-sectoral pro-activity and progress.

Recently, self-reporting tools have been recently gaining currency as useful mechanisms for ensuring that States comply with their international human rights obligations.³⁰ A study analyzing compliance to the UN Convention against Torture concluded that self-reporting tools resulted in improved human rights outcomes.³¹ However, sovereignty and lack of transparency continue to pose the greatest challenge to effective self-reporting and compliance.³² Due to the voluntary nature of self-reporting measures, States may simply omit reporting on its adherence to core capacities, and

²⁷ Gostin, Lawrence O., and Rebecca Katz. “The International Health Regulations: The Governing Framework for Global Health Security.” *The Milbank Quarterly* 94, no. 2 (November 2016): 264–313. <https://doi.org/10.1111/1468-0009.12186>.

²⁸ “WTO Agreements and Public Health.” World Health Organization - World Trade Organization, 2002. https://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf.

²⁹ Ibid.

³⁰ Creamer, Cossette D., and Beth A. Simmons. “The Proof Is in the Process: Self-Reporting Under International Human Rights Treaties – ERRATUM.” *American Journal of International Law* 114, no. 2 (2020): 352. doi:10.1017/ajil.2020.8

³¹ Creamer, Cosette D., and Beth A. Simmons. “Do Self-Reporting Regimes Matter? Evidence from the Convention Against Torture.” *International Studies Quarterly* 63, no. 4 (2019): 1051-064. doi:10.1093/isq/sqz043

³² Mitchell, Ronald B. “Sources of Transparency: Information Systems in International Regimes.” *International Studies Quarterly* 42, no. 1 (1998): 109-30. doi:10.1111/0020-8833.00071.

because of a lack of external assessments to independently evaluate capacities, such States will not be held accountable. With the outbreak of pandemics like the coronavirus, this can particularly result in flawed coordination and responses, exacerbating the spread of the virus. False estimates, or untrue reporting results in overstated competence of States in terms of preparedness and response capacity. In March 2020, the WHO launched a Strategic Preparedness and Response Plan for countering COVID-19, which evaluated which countries are at highest risk of becoming epicenters, based on reporting of compliance with IHR core capacities.³³ In such situations, faulty reporting can impact not just the risk categorization of pandemic spread, but also confound policy recommendations and prevent the WHO from effectively making decisions such as declaring a PHEIC in a timely fashion.

Lack of Funding at the WHO³⁴

The existing global health architecture can only better respond to a health crisis if it has sufficient financial resources. Unfortunately, the WHO's financial reserves are not adequate to cater to the demands of the current pandemic and in fact necessitate a further US\$ 1.74 billion to sustain its current operations to counter COVID-19, up till December 2020.³⁵ The WHO has received 37.8% of the designated funding and there is a 48.7% gap that remains to be fulfilled. It is important to note that most of these contributions have been received from regional organizations or donations vis-à-vis Member States; the World Health Organization slashed assessed contributions (member state dues) by twenty percent (20%) between 2010-2015.³⁶ A factor for this could be the failure on part of the States to recognize international health financing as a global public good. Health Security preparedness for pandemic threats, has never been “the highest priority for the health community nor the security community” and currently there are very few incentives at the country level to

³³ Strategic Preparedness and Response Plan for COVID-19, March 2020 - World Health Organization <https://reliefweb.int/sites/reliefweb.int/files/resources/covid-19-sprp-country-status-12march2020.pdf>

³⁴ Reddy, S., Mazhar, S. & Lencucha, R. The financial sustainability of the World Health Organization and the political economy of global health governance: a review of funding proposals. *Global Health* 14, 119 (2018).

³⁵ “COVID-19 Contributions Tracker.” World Health Organization. World Health Organization. Accessed May 30, 2020. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/donors-and-partners/funding>.

³⁶ “Global Pandemics and Global Health.” Independent Commission on Multilateralism, 2017. <https://www.ipinst.org/wp-content/uploads/2017/10/Global-Pandemics-and-Global-Public-Health1.pdf>.

prioritize pandemic preparedness for international or domestic budgeting cycles³⁷. These heightened financial pressures have increased the dependency of the WHO on voluntary funds.

One of the biggest threats to WHO's success is that less than 20 percent of the budget comes in the form of flexible assessed contributions³⁸ with almost 80 percent of the budget coming in from extra budgetary sources, of which 93 percent is earmarked by donors for specific programs.³⁹ For example the polio eradication campaign utilizes 25 percent of the WHO budget⁴⁰ and if the campaign were to succeed in achieving its goals, the organization would get bankrupt. Moreover, the political rivalry between the U.S. and China may likely affect the funding operations of the WHO as the U.S. who is the largest donor of the agency has threatened to 'make a temporary freeze of the American funding to the WHO permanent'.⁴¹ Trump had already frozen about USD 400 million of the funding and taking away all of its funding (approximately USD 900 million worth of contributions every two years)⁴² would result in a massive financial vacuum for the agency.

The Report of the Panel suggests that in order to redress these financial challenges of the WHO, the multilateral structure ought to mobilize funds for the agency, there needs to be a 10 percent increase in the organization's assessed funding and a further 1 billion should be invested in the organization for supporting measures that will assist the strategic coordination of existing resources. All these measures will eventually result in the WHO being better equipped financially to fight future pandemics, implement the IHR core capacity regime and support the research and development fund.⁴³ In light of these recommendations, issued in 2016, a WHO Contingency Fund for Emergencies (CFE) was set up that was to be financed fully by the Member States according to the scale of their current assessment. The CFE has released nearly USD 9 million to support the

³⁷ "Concept Note: Global Health Security Challenge Fund ." Center for Strategic and International Studies, n.d. <https://www.cgdev.org/sites/default/files/GHS-Challenge-Fund-Concept-Note.pdf>.

³⁸ Jerving, Sara. "WHO Launches Foundation to Expand Its Funding Base." Devex. Devex, May 27, 2020. <https://www.devex.com/news/who-launches-foundation-to-expand-its-funding-base-97340>.

³⁹ *supra* note 25.

⁴⁰ *Ibid*.

⁴¹ Jerving, Sara. "WHO Launches Foundation to Expand Its Funding Base." Devex. Devex, May 27, 2020. <https://www.devex.com/news/who-launches-foundation-to-expand-its-funding-base-97340>.

⁴² Ward, Alex. "Trump Threatens to Permanently Cut WHO Funding If It Doesn't Reform in 30 Days." Vox. Vox, May 19, 2020. <https://www.vox.com/2020/5/19/21263494/coronavirus-trump-who-china-funding-cut-letter>.

⁴³ *supra* note 22, page 10

preparedness and response activities carried out during the COVID-outbreak⁴⁴ but the stats of the required funding suggest that further financial aid is still required. The COVID-19 Strategic Preparedness and Response Plan (SPRP) suggests, that the USD 1.74 billion demand⁴⁵ includes the agency's requirements under the Global Humanitarian Response Plan (GHRP) with over USD 550 million allocated for operations in countries with ongoing or new humanitarian or refugee response crises.⁴⁶

In an effort to broaden its funding base, the WHO on the 27th of May 2020, announced the creation of a foundation (WHO Foundation) that will invite funding from international major donors, the private sector and the general public.⁴⁷ This fund is legally separate from the WHO and from the COVID-19 Solidarity Respond and aims to implement the organization's general programming needs. An average of 70% to 80% of the funds will be directed towards the WHO secretariat while the remaining amount shall be handed to its implementing partners.⁴⁸ While the Foundation's mandate is broader than the Covid-19 pandemic, yet its creation has been a result of the looming threat of the WHO's funding issues.

Problematic Procedure of Declaring a Public Health Emergency of International Concern (PHEIC)⁴⁹

One issue that has been the subject of much speculation in the COVID-19 outbreak is the limitations around the WHO's emergency alert system, including the mechanisms behind the declaration of a public health emergency of international concern (PHEIC).

⁴⁴ "Contingency Fund for Emergencies." World Health Organization. World Health Organization. Accessed May 30, 2020. <https://www.who.int/emergencies/funding/contingency-fund-for-emergencies>.

⁴⁵ Ibid.

⁴⁶ World Health Organization. "COVID-19 WHO Appeal." <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/donors-and-partners/funding>, World Health Organization, 24 May 2020.

⁴⁷ The WHO chief added that the WHO is one of the few international organizations that has not received any funding from the general public.

Jerving, Sara. "WHO Launches Foundation to Expand Its Funding Base." Devex. Devex, May 27, 2020. <https://www.devex.com/news/who-launches-foundation-to-expand-its-funding-base-97340>.

⁴⁸ Ibid.

⁴⁹ "A Framework for Global Outbreak Alert and Response." World Health Organization. World Health Organization, December 20, 2015. https://www.who.int/csr/resources/publications/surveillance/WHO_CDS_CSR_2000_2/en/.

Under Article 1⁵⁰ of the IHR, a PHEIC is defined by two characteristic features: international spread of the disease and need for an internationally coordinated response. Concurrently, Article 12 and Annex 2 of the IHR account for the risk of interference with international traffic as an important part of determining a PHEIC. These can conflict – as was the case in the COVID-19 response – causing confusion regarding the imminence of the disease and its spread. The same article further requires the Director-General of the WHO to consider the information provided by the reporting State, apply scientific principles in assessing the available evidence, assess the risk to human health and of international spread of the disease, and the risk of interference with international traffic – before announcing a PHEIC.

Generally, the WHO has been credited with creating provisions that prioritize scientific evidence (and not political clout) in its decision to declare a PHEIC. Furthermore, the WHO can also rely on unofficial reports of disease-spread in cases where Member States in question are unwilling to comply. However, this is constrained by verification provisions – any information gained from unofficial sources needs to be verified by the member State before effective action can be taken. This is particularly true in the case of Iran during COVID-19, who allegedly failed to report the scale of its coronavirus outbreak even to local health authorities in order to conduct elections and religious proceedings as planned.⁵¹ This resulted in the country becoming an epicenter for disease spread to parts of the Middle East and South Asia. Similar claims have been made against China, the original hub of the coronavirus outbreak, that it delayed informing the WHO of the scale of the initial outbreak, confounding the decision of declaring a PHEIC.⁵²

Even if a State Party does not corroborate an unofficial source, the WHO must be empowered to undertake its own analysis, sharing information transparently to the fullest extent possible in

⁵⁰ See Annex for IHR Articles

World Health Organization International Health Regulations (2005).

<http://www.who.int/ihr/publications/9789241596664/en/>

⁵¹ Behraves, Maysam. “The Untold Story of How Iran Botched the Coronavirus Pandemic.” *Foreign Policy*, March 24, 2020. <https://foreignpolicy.com/2020/03/24/how-iran-botched-coronavirus-pandemic-response/>.

⁵² Leaked WHO files show China Delayed Releasing Important Information to WHO, Sky News, June, 2020 <https://news.sky.com/story/coronavirus-leaked-who-files-show-china-delayed-releasing-important-information-11999027>

accordance with article 11 of the International Health Regulations.⁵³ The World Health Assembly could also amend the decision instrument to reduce States Parties' reporting discretion, avoiding delayed notification or verification by expanding the list of diseases that require automatic notification to expedite the process.

Furthermore, the WHO's emergency response and emergency declaration frameworks must be integrated with International Health Regulations' processes to minimize confusions and increase coordinated action. Presently, the WHO uses the Emergency Response Framework to inform the international community of an outbreak in an incremental manner. However, during the H1N1 and EVD outbreaks, the WHO's use of this framework and the IHR declaration resulted in confusion from decision-makers leading the organization.⁵⁴ At this stage, it would be pertinent to integrate a gradient system in the International Health Regulations through the WHA, or develop clear guidelines under Article 11. These would streamline the process of declaring a PHEIC and allow for more cohesive and decisive action from the multilateral institution during disease outbreaks.

Lack of reform of WHO and its Constitution

Despite the enactment of the IHR and other recommendations, some claim that the WHO's structure is in need of dire reform. In the 2000s, with the rise of non-communicable diseases with zoonotic origins and now, the COVID-19 outbreak, there need to be broader frameworks and additional mechanisms that can compel States to abide by their reporting requirements, as well as implement broad-scale reforms across its health sector.

This can be achieved by either engaging the WHO's law-making powers, while the FCTC and the IHR are welcome exceptions, the WHO has been averse in using its legal powers and its forums such as the WHA in impacting actionable response.⁵⁵ Alternatively, it can also be achieved by amending the WHO Constitution. Any amendments to the WHO Constitution present an arduous

⁵³ Gostin, Lawrence O., Mary C. Bartolo, and Eric A. Friedman. "The International Health Regulations 10 Years On: The Governing Framework for Global Health Security." Georgetown University Law Center, 2015. <https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=2544&context=facpub>.

⁵⁴ Ibid.

⁵⁵ Lakin, A. (1997). *The Legal Powers of the World Health Organization*. *Medical Law International*, 3(1), 23–49.

and cumbersome process. However, if undertaken as part of a systematic development of the normative function of the WHO, it could be helpful in boosting the organization's international role and significance⁵⁶, especially in the post-pandemic world. This can involve mandating external assessments from independent evaluators to effectively sanction or penalize States that were not compliant with IHR core competencies. Alternatively, legal amendments can also be introduced to penalize delayed reporting of novel disease outbreaks of zoonotic origins, which have the potential to turn into epidemics or pandemics.

It is further noted that especially after the Ebola crisis, the case for reform at the WHO revolved exclusively around emergency responses, underplaying the need for strengthening health sectors broadly. All reforms have been centered around preparing the WHO and other agencies to tackle a crisis-ridden outbreak, akin to disaster preparedness at a time where the approach needed to be even more robust investment in strengthening national health systems. At the multilateral front, funds and donors too organized around the need for emergency health planning, and instead of overhauling and empowering existing institutions, erected new ones (such as the World Bank's Pandemic Emergency Facility), to tackle problems that seemingly arise out of a common origin. As Meisterhans purports, "crisis management underscores the importance of strengthening primary health care and public health systems," and it is critical to reform the WHO response mechanism to underpin the tenets of broader reform.⁵⁷

Broader political challenges to the IHR/WHO

The IHR provides a framework for countries across the world to coordinate responses against infectious diseases and generally strengthen health services for their citizens. However, it is now clear that sustained multilateral and bilateral partnerships are needed for low-income countries to make progress with their capacity to detect and contain global health threats due to funding constraints.⁵⁸ But while overcoming the financial barriers to achieving the IHR is fraught with difficulties, overcoming political obstacles may present a yet more daunting challenge.

⁵⁶ Ibid.

⁵⁷ Meisterhans, Nadja. "The World Health Organization in Crisis—Lessons to Be Learned Beyond the Ebola Outbreak." *The Chinese Journal of Global Governance* 2, no. 1 (2016): 1-29.

⁵⁸ International Health Regulations – The Challenges Ahead, *Lancet Journal*, 2007
<https://www.thelancet.com/journals/lancet/article/PIIS0140673607607880/fulltext>

Time and time again, it has been clear that the WHO mechanism is fraught with political considerations. In 2007's World Health Assembly (WHA), Member States rejected Taiwan's bid to gain membership to WHO, largely because of China's concerns about the application – as the latter feared it would be a step in recognizing Taiwan as an independent state.⁵⁹ In 2020's WHA, in the midst of the COVID-19 pandemic, the forum emerged as a battleground between the United States, who sought to undermine the multilateral WHO, China, who was blamed for spreading the pandemic, and EU countries that demanded independent evaluation of the COVID-response.⁶⁰ At the conclusion of this year's WHA, China had agreed to a comprehensive review of its coronavirus response, while providing USD 2 billion in aid, while the WHO faces added scrutiny and an independent evaluation of its management of the pandemic.⁶¹

Global political considerations have never been fully divorced from the functioning of the WHO and IHR. Thus, building a global consensus and fostering global political will is critical in implementing the IHR, organizing funding channels and creating effective and impactful North-South and South-South exchanges to bolster national core capacities of developing and LDCs.

Pakistan and the WHO

Assessing Pakistan's Healthcare Regime

After the passing of the 18th Amendment, healthcare policy and rule-making was devolved to provincial governments. The Federal Ministry of Health was dissolved, with its functionary roles being assigned to other entities, mainly provincial ministries. Theoretically, such an arrangement gives provinces the freedom to design health-based policies in accordance to the specific needs and requirements of the province and its demographics. With the outbreak of the novel coronavirus, Pakistan developed a National Action Plan for COVID-19, establishing inter-provincial and federal-

⁵⁹ Ibid.

⁶⁰ Jacobs, Andrew, and Michael. "U.S.-China Feud Over Coronavirus Erupts at World Health Assembly." The New York Times. The New York Times, May 18, 2020. <https://www.nytimes.com/2020/05/18/health/coronavirus-who-china-trump.html>.

⁶¹ Bociurkiw, Opinion by Michael. "Is China the New Leader on the World Health Stage?" CNN. Cable News Network, May 21, 2020. <https://edition.cnn.com/2020/05/20/opinions/world-health-assembly-xi-trump-bociurkiw/index.html>.

provincial coordination as “a strategic goal to be achieved for the purposes of containment of the disease.”⁶²

Joint External Evaluation of IHR Core Capacities in Pakistan (2016)

The joint external evaluation (JEE) is a voluntary, collaborative, multi-sectoral process to assess country capacities to prevent, detect and rapidly respond to public health risks whether occurring naturally or due to deliberate or accidental events.⁶³ The JEE helps countries identify the most critical gaps within their human and animal health systems in order to prioritize opportunities for enhanced preparedness and response.⁶⁴

In Pakistan’s context, a Joint External Evaluation of IHR Core Capacities (JEE) was conducted in May 2016, charting Pakistan’s compliance across 19 technical indicators passed on prevention, detection, and response to emerging diseases. The evaluation concluded that “despite multiple efforts, [Pakistan] has yet to meet the required core [IHR] capacities,” which could adversely affect the travel and trade.⁶⁵ It was further noted that Pakistan was “not fully prepared to prevent, detect and respond to health threats to protect its population, irrespective of whether the threats arise internally or externally.”⁶⁶

Moreover, while the JEE covered 19 technical areas, in relation to the national legal framework, the Ministry of National Health Services Regulations & Coordination was tasked with identifying gaps in the legal framework. Alarming, however, the JEE noted that “most actions appear to be restricted

⁶² Inter-provincial Coordination and Planning on Healthcare in Pakistan – COVID-19 Law and Policy Challenge, Research Society of International Law.

<https://rsilpak.org/wp-content/uploads/2020/06/The-COVID-19-Law-Policy-Challenge-Inter-Provincial-Coordination-Planning-on-Healthcare-in-Pakistan-RSIL-Pakistan.pdf>

⁶³ Joint External Evaluation Tool and Process Overview – IHR (2005)

<https://apps.who.int/iris/bitstream/handle/10665/252755/WHO-HSE-GCR-2016.18-eng.pdf?sequence=1>

⁶⁴ Joint External Evaluation Tool and Process Overview – IHR (2005)

<https://apps.who.int/iris/bitstream/handle/10665/252755/WHO-HSE-GCR-2016.18-eng.pdf?sequence=1>

⁶⁵ World Health Organization 2017. ‘Joint External Evaluation of IHR Core Capacities of the Islamic Republic of Pakistan – Mission report: 27 April – 6 May 2016’, 1.

<https://www.who.int/ihr/publications/WHO-WHE-CPI-2017.9/en/>

⁶⁶ Ibid.

by current legislation and administrative orders.”⁶⁷ Subsequently, a 5-year costed National Action Plan for Health Security (NAPHS) was published in August 2017. The 2017 NAPHS ends in 2022 and, given the devastating impact of the COVID-19 pandemic, concerted and timely efforts must be made to ensure that any subsequent National Health Security policy addresses the shortcomings already highlighted in the JEE.

Tackling COVID-19 in Pakistan – Impact of Smart Lockdowns

The Government of Pakistan, averse to complete lockdowns, banked on localized “smart” lockdowns to counter the spread of COVID-19. This approach emphasizes using limited scale lockdowns in localities serving as disease hot-spots, while letting the remainder of the city function with normal social distancing rules. When modelled scientifically, such measures have shown promise with reduced infections⁶⁸ and healthier outcomes⁶⁹ overall. A limited pilot conducted in Islamabad also bore positive results, with daily infections decreasing from 700 to 300.⁷⁰ Weeks of full-scale implementation country-wide, resulted in a sharp decline in COVID-19 spread within six weeks. This brought international acclaim to the approach, citing that a dire crisis was prevented through the innovative practice.⁷¹

Within this framework, Pakistan can exhibit leadership and help deepen expertise in innovative containment measures. The IHR competency framework can be further deepened to include SOPs and frameworks pertaining to implementing localized lockdowns for population-dense centres. This can include creating toolkits for implementing smart lockdowns with multiple dimensions, such as designing appropriate legal provisions for enforcement, enhanced surveillance protocols, data-gathering and analysis tools, etc. Particularly for the WHO’s Eastern Mediterranean and South-East Asia Region, with similar demographics and high population density, this can be especially useful. This, coupled with enhanced tracking, tracing and testing competencies can serve as critical

⁶⁷ Ibid, p4.

⁶⁸ Ibarra-Vega D. Lockdown, one, two, none, or smart. Modeling containing covid-19 infection. A conceptual model. The Science of the Total Environment. 2020 Aug;730:138917. DOI: 10.1016/j.scitotenv.2020.138917.

⁶⁹ Daron Acemoglu & Victor Chernozhukov & Iván Werning & Michael D. Whinston, 2020. "Optimal Targeted Lockdowns in a Multi-Group SIR Model," NBER Working Papers 27102, National Bureau of Economic Research, Inc.

⁷⁰ "'Smart Lockdown' Helped Reduce Virus Cases in Islamabad – Officials." Arab News PK. June 20, 2020. Accessed June 25, 2020. <https://www.arabnews.pk/node/1692386/pakistan>.

⁷¹ Saeed Shah, Why Youthful Conservative Pakistan is a Coronavirus Brightspot, July 2020, Wall Street Journal <https://www.wsj.com/articles/why-youthful-conservative-pakistan-is-a-coronavirus-bright-spot-11596297600>

additions to the IHR review process, further enhancing States' ability in countering novel diseases, such as COVID-19.

Recommendations and Conclusion

The outbreak of the novel coronavirus has exposed the fractured nature of global health governance. Critical to IHR is the obligation for all States Parties to establish core capacities to detect, assess, notify and report events, and to respond to public health risks and emergencies.⁷² In an evaluative 2014 Report⁷³, progress was noted by countries in implementing the IHR, as well as efforts to build surveillance systems and the importance of lessons learnt over recent years. However, NFPs reported insufficient authority/capacity, limited involvement/awareness of other governmental sectors, limited investment of national financial and human resources, ongoing emergencies/conflict, extensions of deadlines rather than expanding capacities, and limited efforts to support the weakest countries in building capacities.

States Parties' self-assessment of their implementation of the IHR is limited by the variable quality and reliability of information that is provided, and the self-evaluation cannot be independently evaluated. These challenges remain outstanding in most of the developed world today, which have enabled responses to the coronavirus to be haphazard, reactive and incongruent to the best practices purported by the WHO. For overpopulated centers, such as Brazil and India, this translates into stretching the state's health sectors to the maximum while struggling to increase its internal capacities and implement other measures to contain the virus spread.⁷⁴

The 2014 Report identified specific recommendations to counter the above. However, they are severely limited in scope owing to the structure of the recommendation-based structure of the IHR regime and are thus weak in promoting adherence to the regime. Most of the recommendations revolve around merely commending parties on meeting the minimum requirement for core

⁷² World Health Organization

Implementation of the International Health Regulations (2005): report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation.

http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf

⁷³ Ibid.

⁷⁴ Global Worries as Infections Spike in Russia, Brazil and India, Voice of America News, July 2020
<https://www.voanews.com/covid-19-pandemic/global-worries-infections-spike-russia-brazil-india>

capacities, granting extensions to countries who have not met them, reminding countries of the importance of transparency and encouraging other States to provide technical and financial assistance as needed⁷⁵. These recommendations are inherently weak, provide little by way of guidance and create no oversight mechanisms that can compel States to adhere to these recommendations.

Therefore, it is critical that international organizations, especially those armed with more powers than usual such as the World Health Organization, are reformed and restructured to better tackle common health challenges in the modern era.

After analyzing the structure of the WHO/IHR regime, highlighting problematic areas, we propose the following solutions:

- ❖ **Strengthening the Structure of the WHO:** Specifically, strengthening its monitoring and accountability mechanisms, mandating independent evaluations, and penalizing continued lack of compliance to the IHR regime. This can be achieved by updating recommendations and if required, even amending the WHO Constitution to ensure that adherence and compliance is prioritized.
- ❖ **Implementing Periodic Review Mechanisms:** For the countries under review, the WHO should arrange for an independent field based assessment and this should be presented to the World Health Assembly (or a committee created for this purpose) along with a self-assessment report. Post-review, the WHO Secretariat may develop a cost-action plan on the basis of the costing tool along with a public report that outlines the implementation strategy with requirements for international assistance. This is considered to be more effective in identifying gaps and obtaining support from the international community as required.
- ❖ **Creating a High Level Panel:** Usually formed only in response to crisis events such the EVD outbreak, a permanent high-level council on global public health crisis must be created

⁷⁵ World Health Organization

Implementation of the International Health Regulations (2005): report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation.
http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf

to better respond to a public health crisis. Instead of focusing on health crises, this panel is recommended to regularly monitor and manage issues related to external factors that affect the preparedness and prevention of an epidemic. Such a body can report to the General Assembly in a timely manner, and be representative of Member States while issuing actionable recommendations to target both health emergencies as well as ensure building of IHR core competencies.

❖ **Integrating Risk and a One-Health Approach to WHO Evaluative Frameworks:**

Integrating risk assessment approaches has been linked with effective IHR outcomes in prior WHO reports.⁷⁶ Such approaches should not only be mandated, but the evaluative process must evolve from mere “checklists to a more action-oriented approach.”⁷⁷ Furthermore, integrating a “One Health” approach is also critical.⁷⁸ This approach combines the study of zoonotic (originating from animals) and human-based infectious diseases such as influenza, polio, MERS-CoV, EVD and COVID-19. This approach promotes animal health as well as health of individuals, and will prevent novel diseases from forming in the first place.

❖ **Deepen Funding Pathways to the WHO:** With an operational budget comparable to that of “a medium-sized hospital,” and a mandate as broad as the “attainment of health of all peoples,” the WHO budget is spread over 194 countries, often working to eradicate diseases and ensure immunization in the most vulnerable communities of the world.⁷⁹ While funding concerns have always been a problem, the proliferation of private health initiatives, such as the Bill and Melinda Gates Foundation, the GAVI Alliance, Global Fund, etc. have redirected funds, adversely impacting direct funding to the WHO.⁸⁰ It is critical to fund and empower the WHO to regain back this space from private actors and further invest in

⁷⁶ Ibid.

⁷⁷ Ibid.

⁷⁸ Ibid.

⁷⁹ Lee, Kelley, Katherine Wells, and James Hamblin. "Listen: It's a Small World Health Organization." *The Atlantic*. May 28, 2020. <https://www.theatlantic.com/health/archive/2020/05/its-a-small-world-health-organization/612169/>.

⁸⁰ Reddy, S., Mazhar, S. & Lencucha, R. The financial sustainability of the World Health Organization and the political economy of global health governance: a review of funding proposals. *Global Health* 14, 119 (2018). <https://doi.org/10.1186/s12992-018-0436-8>

reforming broader healthcare sectors particularly in the developing world to prevent outbreaks such as COVID-19 from occurring.⁸¹

- ❖ **Empowering the WHO Regional Network for Local Solutions:** Promoting regional actors to come up with data-backed solutions and other protocols is essential in countering common threats. Pakistan's effective use of 'smart lockdown' strategy, complemented by effective contact tracing and containment measures prevented the country from becoming a major COVID-19 hotspot, similar to Brazil and India.⁸² WHO Regional Offices should incentivize such innovative practices, and streamline the process for such solutions to be disseminated to regional partners in the form of recommendations, SOPs and/or toolkits for enhanced implementation.

⁸¹ Meisterhans, Nadja. "The World Health Organization in Crisis—Lessons to Be Learned Beyond the Ebola Outbreak." *The Chinese Journal of Global Governance* 2, no. 1 (2016): 1-29.

⁸² Global Worries as Infections Spike in Russia, Brazil and India, Voice of America News, July 2020
<https://www.voanews.com/covid-19-pandemic/global-worries-infections-spike-russia-brazil-india>